Objectives: Through the presentation of the case of a patient with Bipolar Affective Disorder who manifests, during a manic episode, a Capgras delusion, we intend to approach the heterogeneity of the manifestation of some symptoms that tend to be specific of concrete psychiatric syndromes.
Methods: Clinical case presentation and non-systematic literature review using Pubmed plataform.
Results: AB, female, 49 years old, diagnosed with Bipolar Affective Disorder. Hospitalized for a manic episode with dysphoric mood, increased energy levels and delusional activity of grandiose and persecutory content. During hospitalization, a Capgras delusion centered on the husband emerged: he was replaced by a stranger, I was able to detect him by smell.
Capgras delusion is a delusional misidentification syndrome characterized by the belief that someone close has been replaced by an imposter. Despite being a rare syndrome, vastly more common in schizophrenia, affecting about 73% of cases, it can also occur in other psychiatric conditions such as dementia syndromes and, less often, mood disorders (16.7%).
Additionally, there are several examples that demonstrate the versatility of psychiatric symptom occurrence in different diagnoses, with first-rank symptoms serving as an example. Described in 1959 by Kurt Schneider, they were considered specific symptoms of schizophrenia, assuming this diagnosis based on the recognition of only one symptom. Over time, its pathognomonic character has become extinct, and its detection in mood disorders and acute psychotic disorder is relatively common.
Another example is the overlap between depressive and anxious symptoms. In fact, anxiety symptoms occur in about 85% of patients diagnosed with depressive disorder and, in turn, the presence of depressive symptoms in about 90% of patients diagnosed with anxiety disorder. This evidence has allowed, over time, a review of the diagnostic criteria for these disorders, leading to a progressive blurring of the threshold between them.
Conclusions: Psychiatric diagnosis is still a delicate task, totally dependent on the clinical interview. The lack of analytical and imaging tests, as well as the absence of pathognomonic symptoms, constitute a particular challenge in diagnosis. For this reason, we highlight the importance of recognizing combinations and patterns of symptoms rather than the specificity of just one symptom.

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EPV0818

A very musical psychopathology – from intrusive musical imagery, to musical obsessions and hallucinations

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Introduction: The semiological spectrum that encompasses musical imagery is a very confusing field, as it is often difficult to understand the nature of the underlying psychopathological phenomenon from the patient's description.
Objectives: The purpose of the authors is to explore reviewing, distinguishing and organizing the concepts such as Intrusive musical imagery, musical obsessions, musical hallucinations, pseudohallucinations and musical palinacousis.
Methods: A brief non-systematized review is presented, using the literature available on PubMed and Google Scholar.
Results: Intrusive musical imagery (earworms, *ohrwurms*, or involuntary musical imagery) occur in more than 85% of general population, without pathology or ear disease. It involves the involuntary repetition of 15-30 seconds of a fragment of music/tune, persisting like a looping soundtrack, not being aversive.
Musical obsessions are a rare form of intrusive imagery, occurring either with other symptoms of Obsessive Compulsive Disorder or isolated ("The stuck song syndrome"). It is recurrent, persistent, intrusive, unintentional, time consuming and causes distress or functional impairment (although not as ego-dystonic and aversive as usually intrusive visual imagery are); preserved insight.
Musical hallucinations occur only in 0,16% in a general hospital; they can be linked to psychiatric diseases, but they are more common in neurological diseases (cerebral lesions, Parkinson's disease, delirium, drug induced…). They are reported to with less controllability, less lyrical content, and lower familiarity, than other forms of inner music; are perceived to arise from an external source and are interpreted as veridical.
Musical Pseudohallucinations can arise after severe hearing loss, in hallucinogen intoxication and in psychotic or non-psychotic disorders (as dissociative states or in borderline personality disorder). They occur in inner/subjective space, but insight can fluctuate.
Musical palinacousis is associated with electroencephalogram and neuroimaging abnormalities, linked to structural brain pathology. There is perseveration (echoing) of an external auditory stimulus occurs after cessation of the stimulus.
Conclusions: A rash classification can lead to misdiagnosis (for e.g. interpreting obsessive symptoms as hallucinatory phenomena or rendering an organic pathology undiagnosed) and the institution of inappropriate therapy. It is important to carefully explore these musical imagery phenomena when patients present these complaints, taking some time to characterize them.

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EPV0819

Delusions of body control: Psychopathological description of a case.

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Introduction: A considerable number of patients with schizophrenia suffer from somatic passivity or delusions of control. So much so, that Schneider considered them as part of the first-rank symptoms.
In these cases, patients can think that feelings, impulses, thoughts, or actions are controlled or imposed by an external force.
Objectives: The objective is to make a psychopathological description of this symptomatology, based on a case report with Anomalous bodily experiences.